

October 15, 2021

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

**EXECUTIVE SUMMARY**

**ALL COUNTY LETTER NO. 21-110**

The purpose of this All County Letter is to inform County Welfare Departments that the *Notice of Approval for CalFresh Benefits (CF 377.1)* and the *Notice of Back CalFresh Benefits (CF 377.9)* were revised.



**KIM JOHNSON**  
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY  
**DEPARTMENT OF SOCIAL SERVICES**  
744 P Street • Sacramento, CA 95814 • [www.cdss.ca.gov](http://www.cdss.ca.gov)



**GAVIN NEWSOM**  
GOVERNOR

October 15, 2021

ALL COUNTY LETTER NO. 21-110

TO: ALL COUNTY WELFARE DIRECTORS  
ALL CALFRESH PROGRAM SPECIALISTS  
ALL CALWORKS PROGRAM SPECIALISTS  
ALL CONSORTIA PROJECT MANAGERS  
ALL QUALITY CONTROL PROGRAM COORDINATORS

SUBJECT: CALFRESH IMPLEMENTATION OF REVISED NOTICES OF ACTION

REFERENCE: [MANUAL OF POLICIES AND PROCEDURES \(MPP\) SECTIONS 23-400.1, 23-400.211, 23-400.22](#)

The purpose of this All County Letter (ACL) is to transmit revised notices for CalFresh.  
The revised Notices of Action (NOAs) include:

- [Notice of Approval for CalFresh Benefits \(CF 377.1\)](#)
- [Notice of Back CalFresh Benefits \(CF 377.9\)](#)

## **Background**

The state and counties provide health and human services benefits to over 13 million Californians through the Statewide Automated Welfare System (SAWS) consortia. The state is working in partnership with the 58 counties, federal oversight agencies, consortium, other state departments, advocate groups, and other stakeholders to consolidate the existing three consortia systems and functionality into one single system, the California Statewide Automated Welfare System (CalSAWS), by 2023. This consolidation effort leverages existing investments in technology, rather than building a new system. As such, the CalSAWS consortium will become the primary automation system for delivering benefits for several decades for all 58 counties in California.

During the Non-State Forms functional design sessions in the Summer of 2019, representatives from the 58 counties, state departments, and consortium, collaborated to map, revise, and improve forms to be shared by all counties once California eligibility systems move to CalSAWS. These forms were used either in the Leader Replacement System (LRS), Consortium IV (C-IV), or California Work Opportunity and Responsibility to Kids Information Network (CalWIN) eligibility system. The efforts between the 58 counties, consortium, and state departments concluded with 108 form requirements for programs managed by both the California Department of Social Services (CDSS) and Department of Health Care Services (DHCS).

Beginning Summer of 2020, in collaboration with CalSAWS and advocate partners, DHCS and CDSS reviewed the 108 form requirements by program to determine which forms would remain non-state forms, transition into state forms, or become obsolete and no longer be used by any counties. The two NOAs this letter transmits were included as a result of this effort. Subsequent revised notices and forms will be released via letter.

### **Implementation Timeline**

The attached revised NOAs will be made available in CalSAWS. CWDs may use previous versions of the NOAs until CalSAWS is implemented within the county, at which time previous versions will become obsolete.

### **No Substitutes Permitted**

With the release of this letter, all revised NOAs are deemed “No Substitutes Permitted” to ensure statewide consistency and avoid unnecessary costs for upkeep of multiple versions.

The visual design of the NOAs is intentional. CWDs must not make any changes to the formatting. However, overprinting modifications may be permitted. Overprinting modifications for purposes other than those specified under [MPP 23-400.211](#) must be pre-approved by the CDSS before use of the forms by CWDs. Refer to [MPP 23-400.22](#) for approval procedures. Requests can be submitted to the CalFresh Policy and Employment Bureau at [CalFreshPolicy@dss.ca.gov](mailto:CalFreshPolicy@dss.ca.gov).

### **Overview of Attachments**

The revised CF 377.1, CF 377.1 Instruction, and CF 377.9 are included as attachments.

To assist CWDs in providing the most accurate CF 377.1 to households, CDSS has provided instructions to help CWDs select the appropriate sections when issuing the CF 377.1. The instructions provide an explanation as to when the specific sections may be used and completed.

The instructions provided are specific to the manual issuance of the CF 377.1. When the NOA is automated by CalSAWS, it is the CWDs responsibility to ensure that the information populated is accurate and correct.

**Important:** All sections will appear on the NOA. If the section is not applicable it must remain blank.

### Revised CalFresh Notices of Action

Form No.	Form Title, Description, Explanation of Changes, and Directions for Use
CF 377.1	<p><b><u>Notice of Approval for CalFresh Benefits</u></b></p> <p>This notice is used to inform households of approval of CalFresh benefits. The notice informs the household of the approved benefit amount and certification period.</p> <p><b>Directions for Use</b></p> <p>The purpose and intent of this form has not changed. Refer to the guidance provided on instructions (attached) and <a href="#">MPP 63-504.2</a>.</p> <p><b>Explanation of Changes</b></p> <ul style="list-style-type: none"><li>• Added “you”<ul style="list-style-type: none"><li>○ State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells <b>you</b> how. Your benefits may not be changed if you ask for a hearing before this action takes place.</li></ul></li><li>• Added “per month”<ul style="list-style-type: none"><li>○ Your benefit amount <b>per month</b> for the rest of your certification period will be \$ _____ from _____ through _____.</li></ul></li><li>• Added “Electronic Benefit Transfer”<ul style="list-style-type: none"><li>○ This is a one-time per year payment and if eligible it will be put into your cash <b>Electronic Benefit Transfer</b> (EBT) account.</li></ul></li></ul>
CF 377.9	<p><b><u>Notice of Back CalFresh Benefits</u></b></p> <p>This notice is used to inform households they have been approved for back CalFresh benefits due to an underissuance. For households approved for back CalFresh benefits who also owe on an overissuance, this notice informs the household how much of</p>

	<p>their back CalFresh benefits will be kept for the repayment and how much will be issued to the household.</p> <p><b>Directions for Use</b></p> <p>The purpose and intent of this form has not changed. Refer to <b>the guidance provided in <a href="#">MPP 63-802</a></b>.</p> <p><b>Explanation of Changes</b></p> <ul style="list-style-type: none"><li>• Added “you”<ul style="list-style-type: none"><li>○ State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells <b>you</b> how. Your benefits may not be changed if you ask for a hearing before this action takes place.</li></ul></li><li>• Previous - “The County has approved back CalFresh benefits for the month(s) of”<ul style="list-style-type: none"><li>○ Revised - The County has approved back CalFresh benefits for the month(s) of _____. You are getting back CalFresh because you were paid less than you were eligible to get.</li></ul></li><li>• Previous - “You should get \$_____ in back CalFresh benefits, but you owe us \$_____. You got another notice about what you owe.”<ul style="list-style-type: none"><li>○ Revised - You were approved for \$ ____ in back CalFresh benefits, but you owe us \$ ____ for previously being issued too much CalFresh benefits. A separate notice was sent to you about what you owe.</li></ul></li><li>• Removed - “The CalFresh benefits you will get will be in one payment unless you ask for them to be repaid in more than one payment. If you want to get your back CalFresh in more than one payment, ask your worker.”</li></ul>
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## Copies and Translations

Forms referenced in this letter are available on the [CDSS Forms-Brochures web page](#).

When all translations are completed per [MPP §21-115.2](#), they are posted on the [Translated Forms and Publications web page](#). For questions on translated materials, please contact Language Services at (916) 651- 8876. Until translations are available, recipients who have elected to receive materials in languages other than English should be sent the English version of the form or notice along with the [GEN 1365-Notice of Language Services](#) and a local contact number.

Per California Code Section 7290 et seq, the CWDs must ensure that effective bilingual services are provided. This requirement may be met through utilization of paid interpreters, qualified bilingual employees, and qualified employees of other agencies or community resources. These services must be provided, free of charge, to the applicant/recipient. If CDSS does not provide translations of a form, it is the county's responsibility to provide the translation if an applicant or recipient requests it.

Additionally, the CWDs must ensure that individuals with disabilities are provided services such as auxiliary aids and services to persons who are deaf or hearing impaired, or persons with impaired speech, vision, or manual skills, where necessary. More information regarding provisions for services to applicants and recipients who are non-English speaking or who have disabilities can be found in [MPP Section 21-115](#).

This ACL and other CDSS Letters and Notices are available on the internet at: <http://www.cdss.ca.gov/inforesources/Letters-and-Notices>.

If you have any questions or need additional guidance regarding the information in this letter, contact the CalFresh Policy and Employment Bureau at [CalFreshPolicy@dss.ca.gov](mailto:CalFreshPolicy@dss.ca.gov).

Sincerely,

***Original Document Signed By***

JENNIFER HERNANDEZ  
Deputy Director  
Family Engagement and Empowerment Division

# NOTICE OF APPROVAL FOR CALFRESH BENEFITS

COUNTY OF \_\_\_\_\_

Notice Date : \_\_\_\_\_  
 Case Name : \_\_\_\_\_  
 Case Number : \_\_\_\_\_  
 Worker Name : \_\_\_\_\_  
 Worker Number : \_\_\_\_\_  
 Telephone Number : \_\_\_\_\_  
 Address : \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(ADDRESSEE)

Questions? Ask your Worker.

**State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells you how. Your benefits may not be changed if you ask for a hearing before this action takes place.**

☐ **YOUR APPLICATION FOR CALFRESH BENEFITS HAS BEEN APPROVED.**

Your initial amount of benefits is: \$ \_\_\_\_\_ for \_\_\_\_\_. Your benefit amount per month for the rest of your certification period will be \$ \_\_\_\_\_ from \_\_\_\_\_ through \_\_\_\_\_.

**IF YOU ALSO APPLIED FOR CASH AID**, and it has not yet been approved, your CalFresh benefits may be lowered or stopped without another notice if your cash aid is approved.

- ☐ Your CalFresh eligibility starts the same day as your cash aid.
- ☐ Your first month's benefits include more than one month's benefits because of the date your application was approved.
- ☐ Your first month's benefits were prorated from the date you filed your application.

☐ **BECAUSE YOU RECEIVED CALFRESH BENEFITS RIGHT AWAY**, we did not require you to give us the following verification:

You must give us this verification before \_\_\_\_\_ or your CalFresh eligibility will stop. You will not get another notice. If the verification you send changes your eligibility or benefits, we will make the change. You **will not** get an advance notice before we take this action.

Your CalFresh household may be eligible to a State Utility Assistance Subsidy (SUAS) payment. If eligible, the county will award you a \$20.01 SUAS cash payment. This is a one-time per year payment and if eligible it will be put into your cash Electronic Benefit Transfer (EBT) account. If you do not have a cash EBT account, one will be set up for you on your CalFresh EBT card. You will not have to do anything to get a new card, but you can use it to cover expenses not otherwise covered by CalFresh. This payment allows the county to use the highest utility deduction (Standard Utility Allowance - SUA) for food benefits. You may use this \$20.01 when you use your EBT card. If you want to know more, please contact your local county office.

**Rules:** These rules apply:  
You may review them at your welfare office.

## YOUR HEARING RIGHTS

**You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice. If you have good cause as to why you were not able to file for a hearing within the 90 days, you may still file for a hearing. If you provide good cause, a hearing may still be scheduled.**

### **If you ask for a hearing before an action on Cash Aid, Medi-Cal, CalFresh, or Child Care takes place:**

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your CalFresh benefits will stay the same until the hearing or the end of your certification period, whichever is earlier.

**If the hearing decision says we are right, you will owe us for any extra Cash Aid, CalFresh or Child Care Services you got.** To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: ☐ Cash Aid ☐ CalFresh  
☐ Child Care

### **While You Wait for a Hearing Decision for:**

#### **Welfare to Work:**

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.

- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

### **Cal-Learn:**

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

## OTHER INFORMATION

### **Medi-Cal Managed Care Plan Members:**

The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

**Child and/or Medical Support:** The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but will keep past due money collected that is owed to the county.

**Family Planning:** Your welfare office will give you information when you ask for it.

**Hearing File:** If you ask for a hearing, the State Hearing Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. **(W&I Code Sections 10850 and 10950.)**



## TO ASK FOR A HEARING:

- **Fill out this page.**
- Make a copy of the front and back of this page for your records. If you ask, your worker will get you a copy of this page.
- **Send or take this page to:**

**OR**

- **Call toll free: 1-800-952-5253** or for hearing or speech impaired who use TDD, 1-800-952-8349.

**To Get Help: You can ask about your hearing rights or for a legal aid referral at the toll-free state phone numbers listed above.** You may get free legal help at your local legal aid or welfare rights office.

**If you do not want to go to the hearing alone, you can bring a friend or someone with you.**

## HEARING REQUEST

I want a hearing due to an action by the Welfare Department of \_\_\_\_\_ County about my: ☐ Cash Aid ☐ CalFresh ☐ Medi-Cal ☐ Other (list) \_\_\_\_\_

**Here's Why:** \_\_\_\_\_

☐ **If you need more space, check here and add a page.**

☐ I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is: \_\_\_\_\_

Name of Person Whose Benefits Were Denied, Changed or Stopped		Date of Birth	Phone Number
Street Address	City	State	Zip Code
Signature			Date
Name of Person Completing This Form			Phone Number

☐ **I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person can be a friend or relative but cannot interpret for you.)**

Name		Phone Number	
Street Address	City	State	Zip Code

## CALFRESH NOTICE OF APPROVAL FOR CALFRESH BENEFITS

CF 377.1 (5/20)

### INSTRUCTIONS

The purpose of the Notice of Approval for CalFresh Benefits (CF 377.1) is to notify households of their CalFresh application approval. The CF 377.1 consists of three sections:

1. Initial Approval Details;
2. Additional Application Details; and
3. Postponed Verification Details

These instructions must be used in conjunction with the revised CF 377.1 (5/20). The instructions provided are specific to the manual issuance of the CF 377.1. When the NOA is automated by CalSAWS, it is the County Welfare Departments (CWD) responsibility to ensure that the information populated is accurate and correct.

#### **Sections on CF 377.1:**

##### **Section One – Initial Approval Details**

- ☐ *YOUR APPLICATION FOR CALFRESH BENEFITS HAS BEEN APPROVED.*

*Your initial amount of benefits is: \$ \_\_\_\_\_ for \_\_\_\_\_.  
Your benefit amount per month for the rest of your certification period will be  
\$ \_\_\_\_\_ from \_\_\_\_\_ through \_\_\_\_\_.*

##### ***Instruction***

- Upon application approval, the CWD will mark the box.
- The CWD must enter the amount of CalFresh benefits approved and the specific month/year (mm/yyyy) based on the initial approval.

**Example:** Your initial amount of benefits is: \$ 58 for 01/2021.

- The CWD must enter the amount of monthly CalFresh benefits that is approved for the remainder of the certification period, and the specific dates (mm/dd/yyyy).

**Example:** Your benefit amount per month for the rest of your certification period will be \$ 194 from 02/01/2021 through 12/31/2021.

##### **Section Two – Additional Application Details**

IF YOU ALSO APPLIED FOR CASH AID, and it has not yet been approved, your CalFresh benefits may be lowered or stopped without another notice if your cash aid is approved.

- ☐ Your CalFresh eligibility starts the same day as your cash aid.

- ☐ Your first month's benefits include more than one month's benefits because of the date your application was approved.
- ☐ Your first month's benefits were prorated from the date you filed your application.

***Instruction***

- The CWD must mark the appropriate box based on household circumstances.

**Section Three – Postponed Verification Details**

- ☐ *BECAUSE YOU RECEIVED CALFRESH BENEFITS RIGHT AWAY, we did not require you to give us the following verification:*

*You must give us this verification before \_\_\_\_\_ or your CalFresh eligibility will stop. You will not get another notice. If the verification you send changes your eligibility or benefits, we will make the change. You will not get an advance notice before we take this action.*

***Instruction***

- The CWD must mark the box, if applicable.
- The CWD must specify which required verifications are missing.
- The CWD must enter the date (mm/dd/yyyy), 30 days from application.
  - **Note:** If the 30th day falls on a weekend or holiday, the NOA must be dated the first business day following the weekend or holiday.

**Example:** Income; 02/15/2021

**Important:** All sections will appear on the NOA, if the section is not applicable it must remain blank.

# NOTICE OF BACK CALFRESH BENEFITS

COUNTY OF \_\_\_\_\_

Notice Date : \_\_\_\_\_  
 Case Name : \_\_\_\_\_  
 Case Number : \_\_\_\_\_  
 Worker Name : \_\_\_\_\_  
 Worker Number : \_\_\_\_\_  
 Telephone Number : \_\_\_\_\_  
 Address : \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(Addressee)


Questions? Ask your Worker.

**State Hearing: If you think this action is wrong, you can ask for a hearing. Pages two and three tell you how. Your benefits may not be changed if you ask for a hearing before this action takes place.**

You are getting back CalFresh because you were paid less than you were eligible to get. The County has approved back CalFresh benefits for the month(s) of \_\_\_\_\_.

Here's why:

☐ You will get \$ \_\_\_\_\_ in back CalFresh benefits.

☐ You were approved for \$ \_\_\_\_\_ in back CalFresh benefits, but you owe us \$ \_\_\_\_\_ for previously being issued too much CalFresh benefits. A separate notice was sent to you about what you owe.

We will keep \$ \_\_\_\_\_ of your back CalFresh benefits to repay what you owe.

You will get \$ \_\_\_\_\_ in back CalFresh benefits.

You still owe \$ \_\_\_\_\_.

Comments:

**Rules:** These rules apply. You may review them at your welfare office: MPP 63-802

## YOUR HEARING RIGHTS

**You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice. If you have good cause as to why you were not able to file for a hearing within the 90 days, you may still file for a hearing. If you provide good cause, a hearing may still be scheduled.**

### **If you ask for a hearing before an action on Cash Aid, Medi-Cal, CalFresh, or Child Care takes place:**

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your CalFresh benefits will stay the same until the hearing or the end of your certification period, whichever is earlier.

**If the hearing decision says we are right, you will owe us for any extra Cash Aid, CalFresh or Child Care Services you got.** To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: ☐ Cash Aid ☐ CalFresh  
☐ Child Care

### **While You Wait for a Hearing Decision for:**

#### **Welfare to Work:**

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.

- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

#### **Cal-Learn:**

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
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## OTHER INFORMATION

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The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

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- Make a copy of the front and back of this page for your records. If you ask, your worker will get you a copy of this page.
- **Send or take this page to:**

**OR**

- **Call toll free: 1-800-952-5253** or for hearing or speech impaired who use TDD, 1-800-952-8349.

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**Here's Why:** \_\_\_\_\_

☐ **If you need more space, check here and add a page.**

☐ I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is: \_\_\_\_\_

Name of Person Whose Benefits Were Denied, Changed or Stopped		Date of Birth	Phone Number
Street Address	City	State	Zip Code
Signature			Date
Name of Person Completing This Form			Phone Number

☐ **I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person can be a friend or relative but cannot interpret for you.)**

Name		Phone Number	
Street Address	City	State	Zip Code